

SEAL Versus Steel

by AWCS(AW/NAC) David Peters

This story is the hardest one I've ever written. I was the crew chief during a Helicopter, Visit, Board, Search and Seizure (HVBSS). We were operating off the coast of South Korea. It was a moonless night. The sea had a slight chop, and there was a steady coastal wind. We could see the lights of the coast directly off the nose of the aircraft.

When the SEAL team came aboard, we discussed their SOP for the extraction. They had been using the Jacob's ladder for recoveries, but my squadron had found that to be difficult (it also increased hover time over the deck). I suggested that we use a double-rescue-strop hoist recovery that another SEAL platoon had shown us. This technique was similar to the procedure used for extracting rescue swimmers from the water.

As usual, we spent time applying operational risk management to this mission. We prepared an ORM brief using input from pilots, aircrew and the SEAL team. We briefed each aspect of the mission. We practiced the extraction procedure on deck, using a static aircraft and the hoist. Next, we practiced over a large deck during the day, then a smaller deck a few days later, debriefing each event. The team had no problems.

A flight of two HH-60H helicopters departed the carrier and established communications with the target ship, a DDG. The insertion, hover cover, and search portions went as planned. My HAC noted the lights from the coasts were causing the pilots' night-vision goggles to bloom, but it was workable.

We watched Dash 2 recover their team, then depart to get fuel. We moved in. Within several minutes I had hoisted aboard all but the last two team members. As they came up to the cabin floor in the helicopter, I covered the closest man's head with my hand and hoisted them both to the full-up position. The outboard man put his feet in the door, and I

grabbed the loop on the rescue strop to bring them aboard. The other SEAL looked like he was riding low in the strop. I pulled twice, but nothing gave. I thought about lowering them back down, but with one man's feet in the door, I would risk losing him. I asked my left gunner for help, keeping a little tension on the strop. But before my crewman could get to the strop, the SEAL fell about 15 feet to the steel deck.

I immediately told the pilots, and we pulled in the other SEAL. I asked the HAC to report a medical emergency to the ship, and, after some confusion, we moved off the deck. The last view I had was of the SEAL face down on the deck with his weapon still slung. A pool of blood was forming around his head. He wasn't moving.

The SEAL's Kevlar helmet, with strap and chin cup secured, had been knocked off his head and was lying in the safety nets. One of the ship's crew came out on the deck with a flashlight. As he shined the light on the SEAL, incredibly, the SEAL got up and walked to medical! We landed and had the injured SEAL back-boarded and transported to a hospital within minutes.

The debrief was tough. The injured SEAL was their platoon LCPO, and I had found him to be the most knowledgeable and professional SEAL I'd worked with. I felt terrible and didn't know what to say. The SEAL's prognosis was poor. I was afraid he would die. I didn't sleep for a few nights, but we eventually heard that he was awake and responsive and would be transferred stateside as soon as possible.



Photo-composite by Allan Amen

This nightmare occurred because of several factors. I believe the SEAL did not have his weapon secured, and the stock caught on the cabin-door track. The sling then cut off the blood flow to his head, causing him to black out. I didn't notice the problem and wasn't prepared to deal with the situation. The cabin was dark. The HAC had asked if I wanted the cabin lighting on during the extraction, but I had declined because of the lights from the coast.

We had briefed having the SEAL team secure their weapons before hoisting. Our ORM process had covered the general hazards of hoisting but hadn't covered the possibility of a team member becoming hung up in the door.

We learned several simple lessons from this mishap. First, hoist recoveries are effective if done correctly. The platoon CPO asked his team how they felt about the hoist recovery, and, to a man, they agreed it was the safest recovery method they had used. To prevent mishaps, the

rope master has to do a final check on deck prior to hoisting. All loose equipment, including weapons, should be hoisted separately in kit bags. The cabin lighting should be used. All team members and aircrew should be briefed on this mishap before similar operations.

The aftermath of this event opened my eyes to several attitudes we mere mortals hold about special operations personnel and ORM. In my conversations with other officers and chiefs, the prevailing attitude was "They're SEALs, and it's part of the job." I disagree. We all take risks in our work, but to write off a severe injury as "part of the job" is just asking for more.

ORM is not the answer to all our operational prayers, but it is an outstanding tool and always should be employed. It doesn't guarantee accident-free operations. Experience and communication always will have the greatest real-time influence. I get frustrated trying to communicate my experience to other teams and squadrons. There seems to be no forum to exchange lessons learned between the helicopter and special operations communities. There is no model manager for the CSAR-NSW mission. Other high-risk missions have model managers to standardize procedures and equipment, and they are in place to keep Sailors from getting hurt or being placed in unnecessary risk. The CSAR-NSW mission should have one, too. 🦅

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